Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

MHHS SOUTHWEST HOSPITAL
P O BOX 201367
HOUSTON TX 77216

Respondent Name

TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number

M4-12-2887-01

Carrier's Austin Representative Box

Box Number 54

MFDR Date Received

May 10, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Patient was admitted thru the emergency room, per state guidelines authorization is NOT required. Texas Mutual did not provided authorization, stating authorization is not required for Emergency Room admit. This bill has denied multiple times indicating pre-authorization is required."

Amount in Dispute: $140,014.16

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The following is the carrier's statement with respect to this dispute. Texas Mutual requires additional time to respond to this dispute and will submit a supplemental response shortly."

Response Submitted by: Texas Mutual Insurance Company, 6210 E. Highway 290, Austin TX 78723

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 15, 2011 to October 27, 2011	Inpatient Hospital Surgical Services	$140,014.16	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Texas Administrative Code §134.600 requires preauthorization for specific treatments and services.
3. 28 Texas Administrative Code §133.2, effective July 27, 2008, 33 TexReg 5701, defines a medical emergency.

4. The services in dispute were reduced/denied by the respondent with the following reason code:

   Explanation of benefits dated December 15, 2011
   - CAC-197 – PRECERTIFICATION/AUTHORIZATION/NOTIFICATION ABSENT.
   - 930 – PRE-AUTHORIZATION REQUIRED, REIMBURSEMENT DENIED.

   Explanation of benefits dated January 6, 2012
   - CAC-193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
   - CAC-197 – PRECERTIFICATION/AUTHORIZATION/NOTIFICATION ABSENT.
   - 891 – NO ADDITIONAL PAYMENT AFTER RECONSIDERATION
   - 930 – PRE-AUTHORIZATION REQUIRED, REIMBURSEMENT DENIED.

   Explanation of benefits dated January 25, 2012
   - CAC-18 – DUPLICATE CLAIM/SERVICE.
   - 878 – APPEAL (REQUEST FOR RECONSIDERATION) PREVIOUSLY PROCESSED. REFER TO RULE 133.250(H)

   Explanation of benefits dated April 13, 2012
   - CAC-18 – DUPLICATE CLAIM/SERVICE.
   - 878 – APPEAL (REQUEST FOR RECONSIDERATION) PREVIOUSLY PROCESSED. REFER TO RULE 133.250(H)

Issues

1. Did the requestor obtain preauthorization approval prior to providing the health care in dispute in accordance with 28 Texas Administrative Code §134.600?
2. Did the surgery in dispute meet the criteria to sufficiently support a medical emergency in accordance with 28 Texas Administrative Code §133.2?
3. Is the requestor entitled to reimbursement?

Findings

1. Review of the respondent's submitted documentation finds the emergency admission dated October 15, 2011 shows the admitting diagnosis code 780.79 (Malaise and fatigue NEC) with a chief complaint of weakness, bilateral leg pain…PRESENTING COMPLAINT: Right upper extremity weakness for 10 days, bilateral lower extremity pain and weakness for 5 days…HISTORY OF PRESENT ILLNESS:…male with a known history of spinal stenosis status post lumbar laminectomy in 2006, status post spinal cord stimulator placement in 2009. Patient says he has had ongoing fever for the past 1 month, was previously admitted in Citizens Hospital in Victoria…CT myelogram…after the procedure patient says he developed pain and weakness of his right upper extremity…developed severe pain in both lower extremities…aggravated by walking or movement, improved by pain medication…no associated urine or stool incontinence…other than above, patient denies any complaints…PHYSICAL EXAMINATION: GENERAL: Awake, alert, weak-looking, in no apparent distress…" Progress Note dated October 17, 2011 states, "SUBJECTIVE: Patient continues to have significant lumbosacral area pain…PLAN: will change the patient to inpatient status as per case management recommendation…the plan would be to take out the spinal cord stimulator based on the recommendation from ID and neurology given the patient's clinical findings." Discharge Summary dated October 27, 2011 states, "CT myelogram of the total spine showed mild spondylosis of the T9 to T10 region and lumbar spine…neurostimulator was removed on 10/18/2011 with laminectomy procedure by Dr. Berry…Dr. Berry took patient to surgery again 10/21/2011, where patient had thoracic laminectomy, decompression and resection of subdural scar tissue…"

2. 28 Texas Administrative Code §134.600 (c)(1)(A) and (B), states "The carrier is liable for all reasonable and necessary medical costs relating to the health care: (1) listed in subsection (p) or (q) of this section only when the following situations occur:
   (A) An emergency, as defined in Chapter 133 of this title (relating to General Medical Provisions);
   (B) Preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care."

   28 Texas Administrative Code §134.600(p)(2) states "Non-emergency health care requiring preauthorization includes: (2) inpatient hospital admissions, including the principal scheduled procedure(s) and the length of stay."

28 Texas Administrative Code §133.2 (3) defines "Emergency—Either a medical or mental health emergency as follows: (A) a medical emergency is the sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including sever pain, that the absence of immediate medical attention could reasonably be expected to result in:

(i) Placing the patient's health or bodily functions in serious jeopardy, or

(ii) Serious dysfunction of any body organ or part."

Review of the submitted documentation finds that the requestor did not submit documentation to sufficiently support that the inpatient hospital surgical services performed from October 15, 2011 through October 27, 2011 was on an emergency basis as defined in 28 Texas Administrative Code §133.2 (3). Therefore, the disputed services required preauthorization per 28 Texas Administrative Code §134.600(p)(1).

3. Review of the submitted documentation finds that the requestor did not submit documentation to support preauthorization was obtained for the inpatient hospital surgical services performed from October 15, 2011 through October 27, 2011. Therefore, no reimbursement is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	June 22, 2012 Date
Signature	Medical Fee Dispute Resolution Manager	June 22, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.